Medical *Clearance* Form

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____

Phone: _____

Email: _____

MRN: _____

REFERRING PHYSICIAN

Physician Name: _____

Department: _____

Phone: _____

Fax: _____

Patient's Primary Health Concerns/Exercise Restrictions:

_____

_____

Recommended exercise intensity: ◯ Light ◯ Moderate ◯ Vigorous

PROGRAMS REFERRAL (CHOOSE ONE)

◯ **Fitness Center Membership:** Patient will be evaluated and an exercise physiologist will make class and/or exercise recommendations based on the evaluation.

◯ **Exercise is Medicine® Program:** Patient will be enrolled in an 8-week program that will involve one-on-one sessions with an exercise physiologist. These sessions will include thorough evaluation and exercise treatment based on the patient's medical diagnosis.

Dx: _____

◯ **Pink Program:** A 12-week holistic, exercise, support, nutrition program for people undergoing treatment for breast cancer or who have completed treatment within the last 8 months.

Dx: _____

Physician Signature: _____

Piedmont Atlanta Fitness Center
2001 Peachtree Road, N.W., Suite 100, Atlanta, Georgia 30309
Phone 404.605.1966 • Fax 404.609.6866 • piedmont.org/fitness

Piedmont ATLANTA